Healthcare in the United States: A Brief Guide

By: Aman Grover

I've heard a lot about Obamacare on the news. What is it?

Obamacare is a nickname for the Affordable Care Act (ACA). The bill was passed into law in March of 2010, and was slowly phased into so that the biggest parts of it didn't really get going until 2014. It was created because in 2009, the United States healthcare system was a disaster - whether it still is or isn't will be a debate we get to in just a bit.

What's the big deal? Back in 2009, the US spent significantly more of its tax dollars than countries such as Japan, the UK, Australia, and a couple more. The difference? All those countries mentioned offer universal health care, while the United States had 44 million people left uninsured. What's more, countries like Canada, France, Australia, the Netherlands, and some others, spend less than 10% of their nation's GDP on healthcare costs, while the US spends upwards of 17% of our GDP on healthcare. Despite that huge disparity, the health outcomes we get are highly similar to the aforementioned countries, or in some instances, worse .

What happened to all those uninsured people?

Well there were 44 million of them, so obviously something had to be done. When uninsured people were sick and went to the hospital, they did end up receiving care, and if they later couldn't pay those costs, it'd essentially be absorbed by the rest of us paying higher healthcare prices or taxes because the government has to subsidize public hospitals. This was more of a "Oh, you fell down the stairs and broke 12 bones - let me patch you up" rather than anything comprehensive. For example, those with diabetes that couldn't afford health insurance couldn't come in to the hospital each week for their supply of insulin and expect the government to just pick up the tab. Emergency care was also been decreasing at an alarming rate, primarily because of the insane costs associated with it. While more and more accidents that are needing of emergency medical attention have been taking place over the past few decades, trauma centers and emergency departments across the nation were closing, primarily in low income areas where people simply couldn't afford the treatment they needed. So we had nothing close to the universal healthcare of many other developed countries, but rather an extremely inefficient and expensive system.

So how was the government helping people the whole time?

They had two major programs: Medicare (which provided insurance to elderly people) and Medicaid (which provided insurance to many poor people). Medicare covers about 15% of Americans, and is a "national social insurance program run and administered by the federal government." It's also the closest thing the US has to what most people refer to as a single

payer system, which is a healthcare system in which all people are covered by one type of insurance. Don't get the wrong idea though - Medicare is still pretty complicated.

Why were so many people uninsured?

Well a lot of people simply couldn't afford health insurance. But back in 2009, insurers could also deny you access to healthcare if you had a preexisting condition, which is an extremely broad term. The only way to get around this legal clause was if you worked for a large company and got insurance through them, which then of course incentivized people to work for large companies.

So how did the Affordable Care Act try to change all this?

The goal of the Affordable Care Act was to make the labor market a little less crazy, decrease health related bankruptcies (the most common cause of bankruptcy in the United States), and ultimately bring insurance to those 44 million people without any health insurance - all while decreasing the overall amount of money that we as a country spend on healthcare.

So first it tried to make healthcare far more accessible by creating healthcare exchanges, in which private insurance companies could compete for people's business but couldn't discriminate against anyone based on gender or pre existing conditions. The Affordable Care Act would also expand Medicaid (which we'll speak in great depth about in just a bit) to get insurance to more poor people. It also required employees with more than 50 employees to provide affordable insurance to their employees, or else they'd have to pay a huge penalty.

This would all be paid for by cost control measures, which ranged from getting tougher on medicare fraud to incentivizing hospitals to keep elderly patients so they don't get keep getting readmitted to the hospital (which ends up being costlier). They also added a new tax on tanning salons and increase in the Medicare payroll tax for people who earn an income over $250,000 a year.

So the Affordable Care Act was phased into slowly, and we didn't really get to the real core of it until 2014. You remember the healthcare exchanges I had mentioned a bit earlier? You might have heard of them when they were rolled out in late 2013….and were labelled a flat out disaster. The website of the exchanges, healthcare.gov, was plagued with glitches and many people just couldn't get it to work. Perhaps it made the experience a bit easier than it was before, but it was still a total disaster, and nowhere near what it was supposed to be. What hasn't been as widely reported is that since then, the site has come a long way, and it's been regarded as relatively easy to sign up for health insurance now. In general, the exchanges work very well, and more than 12 million million Americans have signed up for insurance through them. While insurance premiums are still rising, they're going up more slowly than they were before the exchanges were being offered, and more insurers are participating, which means that there's more competition in the market (so there'll be lower prices for consumers). Plus the law

is costing significantly less than expected because fewer employers than expected have been dropped fewer people than expected off their insurance, and the job market doesn't seem to have really been negatively affected either. If anything, it's actually led to more freedom in the labor market, because people are no longer being forced to work for large corporations to guarantee they and their family receive health insurance.

For people who can get insurance now but couldn't before, either because of preexisting conditions or because they simply couldn't afford it without the government subsidies that have been put into place, the Affordable Care Act is a huge deal. Most importantly, all those claims that the "healthcare system will collapse" have been shown to be false - everything remains afloat. Instead, the uninsurance rates in the United States have dropped significantly and early signs indicate that at least in some areas, the Affordable Care Act has caused health to improve. That said, many millions of people remain uninsured, and under-insurance, a case where people technically have health insurance but still end up with medical bills they can't afford, remains a huge problem. And while the growth of healthcare costs overall has slowed, we still spend around 17% of our nation's GDP on healthcare, while most other developed countries spend far less and their citizen's end up much better off health-wise.

So yes, if nothing changes, then health care costs will still crush us in the long run. You may have noticed that based off my description of it, the Affordable Care Act wasn't really anything too radical - the 12 million people who got insurance through the exchanges account for a bit less than a mere 4% of the American population. For the vast majority of people, very little has ended up changing, and that means the underlying problems haven't really changed. We spend way too much on healthcare for the minimal returns that we get.

Was the bill a succes? Well, in a sense. Things are certainly better before, but there are certainly a number of problems left to deal with, especially the fact that we are nowhere near a path to sustainable healthcare spending. The old system definitely was NOT working, and the Affordable Care Act is working in so far as it's job is to get health insurance to those who don't have it without causing a disturbance to the health insurance ecosystem for most other people. But when I say "the old system," it's important to remember that the Affordable Care Act didn't truly replace the healthcare system we previously had, so much as it expanded it. Now the fact that so many insurers are bringing more and more plans to exchanges indicates that it's going to continue working, and the fact that it's survived all the legal attempts thus far to shut it down doesn't hurt either.

How can regulation be used to lower costs while preserving quality?

That's part of the balancing act that can make healthcare so complex. It's easy for us to get health care reform quite clearly, but we'd likely disrupt the private market in the process. We

don’t want to mess too much with the private market, give that it has a net value of over $500 billion, so any damage to it could have catastrophic economic consequences. Anyway, healthcare can be made cheaper as well, but this is primarily through government regulation. The government will subsidize certain procedures, plans, etc. What it is that they spend money towards will vary, but the outcome of the lower prices will remain the same. Insuring more people helps lower the cost for everyone because the increased demand allows for decreased prices - the problem is the government then has to spend more tax dollars towards health care. Regardless, the government worked very hard to make sure the maximum number of people possible receive health insurance, as they are placing a fine on anyone who can afford health insurance but still chooses not to purchase it. This fine is known as the individual mandate.

You’re mentioned Medicare a few times. How does it work?

Just to remind you, Medicare is essentially provides healthcare for the elderly, provided they paid into the system. It’s not anything new, and was actually created all the way back in 1966. There are a four main parts to Medicare - Part A, Part B, Part C, and Part D - each of which we'll go over now. Medicare Part A covers you if you’re hospitalized, and is pretty much free if you’re over the age of 65. Almost nobody doesn’t end up getting it when they need it. Medicare Part B covers any outpatient services (“medical procedures or tests that can be done in a medical center without an overnight stay”), has a pretty low deductible (“a specified amount of money that the insured must pay before an insurance company will pay a claim”), and covers quite a few other stuff, including most tests and procedures that you might need to get outside of the hospital, along with a lot of medical equipment that you might need to use. There are also private supplemental Medigap policies that will often cover the copays or coinsurance, or may even add extra benefits. Most people end up buying one of these policies too, and so elderly individuals will often end up paying a significantly lower amount than one would expect. Medicare Part C (hold on - just one more part after this and we’re done) is an opportunity for private companies to offer Medicare-like benefits as an alternative to to the government. If they can do a better or equivalent job as the government and for less money, they get to keep the extra profit. Medicare beneficiaries can also into such Medicare advantage plans as opposed to traditional Medicare. Because some people have different benefits that appeal to them, this wider range of options proves helpful to many. About a quarter of Medicare beneficiaries choose such a plan. Medicare Part D (the last one - yay) contains prescription drug plans, which are designed and run by private insurance companies. These plans are approved and paid for by the federal government. Individual beneficiaries pick they plan they like based upon whichever drugs they need.

What’s Medicaid?

While Medicare is a federally run program, Medicaid is a state based program. It’s essentially supposed to provide healthcare coverage for the poor. There are some basic minimal federal guidelines that are set, and then each state get’s to add their own individual rules as well. Some states are more generous in their coverage, and some states are less generous. Since Medicaid

is generally meant to cover those on the lower end of the income spectrum, there are a number of standards regarding household income and number of people living in a household that determine whether someone qualifies for Medicaid. The line is set pretty low, given that a person who makes the federal minimum wage and has one child is above the poverty line.

Medicaid must cover kids under 6 years of age to 133% of the federal poverty line (FPL) and kids aged 6-18 to 100% of the FPL. The State's Children Health Insurance Plan (SCHIP) bumps this up to 300% in most states. Pregnant women are covered up to 133% of the FPL, and parents are covered at a rate determined to be equal to the 1996 welfare levels.

If you're looking at this, something might stick out - adults without children aren't mentioned at all. In fact, in most states, the poorest adults without children, even those who make nothing at all, don't get Medicaid. Another problem with Medicaid is determining how parents should be covered based upon the 1996 welfare levels, since these levels can get extremely low. So low, that in fact, just a few years ago, a couple in Arkansas that made $3280 a year and had two children were considered "too rich for Medicaid."

And so while some states are much more generous, many states require people to be extremely poor to qualify for Medicaid. This was a problem that was supposed to be fixed by a Medicaid Expansion in the Affordable Care Act, as everyone who earned under 138% of the FPL was supposed to receive Medicaid, regardless of whether or not they have children. This expansion would have finally made Medicaid a universal problem for the poor, but notice I said "*would have*."

In the court case *National Federation of Independent Business v. Sebelius,* the Supreme Court upheld the constitutionality of the requirement that all Americans have affordable health insurance coverage. They, however, made the Medicaid expansion option, and many states decided to refuse it, which left an additional 5 million low income earners with no insurance.

Why are health care costs so high in the United States compared to other countries?

First let's discuss some common fallacies, because these are likely to come up in debate, so it's nice to have some refutation material. One common belief is that doctors are scared of malpractice suits, and so they perform an excessive number of tests to make sure they're safe. Sounds fair enough, right? Well, there have been states who had malpractice law reform to alleviate this problem. However, in those states, such as Texas, healthcare costs dropped by a mere 1%, meaning doctors performing too many tests obviously wasn't causing any huge problems. The problem isn't overutilization either - Americans go to the doctor less than Europeans but still have significantly more expensive healthcare. The problem also isn't high rates of obesity in America - disease prevalence has been shows to barely affect health care costs in any manner whatsoever.

Instead, the problem lies within our government, which doesn't negotiate as aggressively with healthcare providers, drug manufacturers, and medical device makes as other countries. Take for example the United Kingdom. They will announce to all the companies who make a certain medical product - let's say prosthetic arms - and say, "One of you companies will get to make a huge supply of prosthetic arms for everybody who is covered by the National Health Service (NHS) here in the UK, but the devices must be safe and cheap, or we'll have to give our business to another company." This motivates all the prosthetic arm companies to offer extremely low prices because of the huge contract that they'd get if they won.

In the United States, we don't have that type of centralized negotiation, so we don't really have the kind of leverage that comes with it either. The exception to this is Medicare, the government funded healthcare program for the elderly, which always offers the lowest prices - not coincidentally. Other than that though, US providers charge whatever they think they can get away with, and unfortunately, they can usually get away with a lot. After all, it's difficult to put a price on not dying. If you're going to die unless you're treated with a certain drug, you will pay whatever you need to pay to get that drug, whether it's $5 or $500. This is called inelastic demand - you will buy the good regardless of any outside factors because you still need it. Thus, you can't negotiate effectively on your own behalf when trying to get health care services, because you NEED to buy the healthcare services regardless. This is probably one of the most pressing issues regarding modern health care - we must find a way to lower the insanely high costs.